DR. MICHAEL S. SALTER
Millennium Medical & Surgical Foot Specialists
Diseases, Deformities & Injuries of the Foot and Ankle

1460 Walton Boulevard
Rochester Hills, Michigan 48309
Telephone (248) 651-0653
Facsimile (248) 651-3697

32255 Northwestern Highway
Farmington Hills, Michigan 48334
Telephone (248) 352-5920
Facsimile (248) 352-6388

We ask that you read this introductory letter carefully. It provides our office policies, some general information about your insurance and your responsibilities as a patient in our office.

Welcome to our office...

In order for us to provide you with courteous and efficient service and the best of health care, we ask you to review and print this letter for future reference. We have attempted to anticipate your questions and provide you with as much information as possible about our practice in order to make our relationship a more pleasant one.

Our entire staff is committed to providing you with the finest podiatric medical and surgical care available in this area. We have selected our office staff for their training, knowledge, and desire to help people. We take pride in our staff, and we would like you to share our confidence in them.

General Information...

Our medical care is confined to Podiatric Medicine and Surgery of the foot and ankle. We specifically take care of diseases, deformities, and injuries of the foot and ankle. This includes the medical and surgical care of the bones, joints, nails, and skin of the foot and ankle. We are affiliated with William Beaumont Hospitals, McLaren Oakland Hospital in Pontiac, Sinai-Grace Hospital, Huron Valley Hospital, and the Detroit Medical Center-Hospitals Group. If you are at any Emergency Center anywhere, you can request that we are contacted and if necessary arrange for your transfer to one of our facilities, if this is consistent with your best interest at the time. Many fractures and sprains can be splinted in the Emergency Center and referred to our office for treatment. You should obtain any x-rays or testing and bring them along with you to our office for reviewing.

Appointments...

Patients are seen by appointment only. To obtain an appointment please call the office during regular business hours. A receptionist will assist you in obtaining a convenient time to fit your schedule. We understand that your time is valuable and we will make every effort to see you at your scheduled time. It is important to us that your time spent in the office is as informative and pleasant as possible. Understandably, our office routine is occasionally disrupted by surgery, emergencies, or prolonged and difficult problems that must take priority. We appreciate your understanding and patience when this happens, and as such we promise to devote the appropriate attention to your care. For the same reason, we appreciate your advance cancellation of an appointment that you cannot keep. A charge will be made for broken appointments not cancelled without a twenty-four hour advance notice.

Telephone...

People sometimes call the office wishing to speak to the doctor. We have instructed our assistants to handle all incoming telephone traffic. Transmission of messages by our staff can enable us to take care of your needs more rapidly than if we handled each call personally. Our telephone policies are meant to allow us to care for patients with a minimum of interruptions and to answer necessary questions and take care of urgent problems. We hope that you understand this and will assist us with your cooperation. However, telephone calls used in lieu of an office visit will be billed accordingly. Outside of regular office hours, if your medical problems are urgent, or if you encounter a problem which cannot wait until regular office hours, our twenty-four hour a day answering service will locate us and we will contact you. You may go directly to the Emergency Center at any William Beaumont Hospital facility, McLaren-Oakland Hospital in Pontiac, or any DMC-Hospital Group location.

Prescriptions and Refills...

Prescriptions and refills are issued during office hours only. At other times, it is difficult to determine if a prescription or refill is indicated since your medical records are not available for review by a doctor. Federal law prevents us from prescribing narcotic medications over the phone. These prescriptions must be hand signed by the physician. This means that the doctor will not routinely refill prescriptions during the evenings or weekends. The best method for having a routine prescription issued or refilled is to call our office, provide the medication name, dosage, and confirm the location and phone number of your pharmacy.

Insurance...

The quality and extent of health insurance coverage varies widely, and we suggest that you make yourself aware of the coverage and limitations of your particular policy. Please understand that not all services are a ***"Covered"*** benefit in all insurance policies. Your policy is a contract between you and your insurance company. We are not a party to that contract. We cannot always determine the benefits of your insurance policy. Medicare, Blue Shield, and most private insurance companies select certain services that they will not cover. Payment for these services is the responsibility of you, the patient.

We strongly encourage that you carefully read your insurance policy so that you will know the conditions and circumstances of the coverage that is available to you.

When we are able to verify your coverage and benefits in advance for any of the plans we currently participate with, we will "accept assignment" of your insurance benefits and we will bill the carrier(s) directly. "Accepting assignment" means that your insurance company may (should) send us the bulk of the payment for treatment and that you, the patient, will pay us directly for any deductibles, co-payments and fees for "***non-covered***" services. When the insurance company does not pay us, or at sixty-days from the date of billing the insurance company (insurance companies are required by law to pay or deny claims within thirty days), whichever occurs first, you will be responsible for any remaining balance. If an insurance company later pays us for an uncovered service, we will refund to you any overpayment(s) that you have made directly to us.

We participate fully with all Blue Shield of Michigan plans, Blue Care Network, Medicare plans, Aetna, Cigna, HAP, Cofinity, United Healthcare and Tricare. There are many other individual companies we also participate with so please consult your plan directory or our front desk staff for our participation status. "*Full participation*" means that we accept their payment in full for services (Excluding any deductibles, co-payments required by your insurance carrier, uncovered services or supplies. These fees are payable at the time service is provided.)

For those patients with plans that require referral by a Primary Care Physician, it is your responsibility to first obtain the referral authorization and make sure that is with you or on file in our office at the time services are provided. In most cases we cannot call for a referral on the day of service. Each plan is different; some require a written referral while others have only a referral number. Patients requiring a referral for care or evaluation cannot be seen without a valid referral on file.

Liability of Workers' Compensation and Accident Insurance Claims...

Payment of a bill is the direct responsibility of the individual who has received the medical treatment or the signed guarantor. We do not feel that involvement in any liability action is reason for a delay in our payment. If Workers' Compensation covers your medical care, it is your responsibility to present a letter of authorization for your treatment along with billing instructions. If your visits are the result of an auto accident, be prepared to provide the details of the accident and injuries. If seen in the office because of an employment related injury, please present approval for treatment. Information provided should include the name, address, and phone number of the insurance carrier, and the file or claim number. If you do not have the authorization, the bill is your responsibility at the time of treatment. If a medical report is needed, for any reason, we will comply, but there is a fee to you for this service. Most claims require seven to ten days to complete.

Fees...

Our fees are generally considered to fall within the usual, customary and acceptable range by most insurance companies. Therefore, services are covered up to the maximum allowance determined by each carrier, except for those carriers who reimburse on an arbitrary "schedule of fees", which bears no relationship to the current standard and cost of care in our area.

As many of you know, statement and billing costs have become expensive. In order to help keep your medical costs down, we ask that you pay for office visits and treatments at the time service is rendered, unless payment arrangements have been approved in advance, and IN WRITING by the doctor. There is a statement charge added for those fees not paid at the time of your visit. Requests for non-customary assistance such as disability reports and special information requests are not included in our office fees and billed separately to the patient. X-rays and charts are a part of your permanent medical record in our office. X-ray copies can be provided upon advance notice and payment of duplicating charges.

We will always be happy to discuss any fee or charge with you. Please feel free to call or stop in at an appropriate time for a full explanation by the doctor or staff. Bills not paid within sixty-days become past due accounts. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly and discuss them with us personally.

We wish to stress that responsibility for payment is always the patient's obligation, regardless of any insurance coverage.

Please advise the front desk administrative assistant of any changes in your address, phone number, marital status, responsible party for bills, employment status, or insurance coverage that may have occurred since your last visit.

We are a caring and committed office of physicians and staff here to provide you with the finest quality care.

Dr. Michael Salter

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Welcome To Our Office . . . .

Please **print** and complete the following information for our files.

Last Name	First	Middle Initial	Today's Date

Residence Address Apt. #	City	State	Zip	Marital Status Single Married Widowed Divorced

Patient's Birthdate	Patient's Social Security Number	Patient's Employer

Home Phone Cell Phone	Age	Sex Male Female	Business Phone

Whom may we thank for referring you to our office?	Address/City/State

Spouse's Name, Parent's or Guardian's Name if a Minor	Birthdate	Social Security Number of Spouse, Parent or Guardian

Name, address and phone number of person outside your home to contact in case of emergency?	Relationship

Person responsible for account - **If other than patient please list name, address, birthdate and relationship to patient**

Do you have medical insurance? Yes No	Insurance Company Name	Subscriber Name, Social Security Number and Birthdate

Is insurance through your employer? Yes No	Is there a second insurance company? Yes No	Second Insurance Company Name	Subscriber Name, Social Security Number and Birthdate

List any medical conditions you have	Subscriber's Employer

Name of family physician	Phone	Are you currently under this physician's care? Yes No

If yes, for what	May we contact your physician for your health records? Yes No Address

Previous treatment by a podiatrist? No Yes Name?	When?	For what?

Patient's height	Weight	Shoe size	Occupation

Reason for today's visit?

_____

_____

_____

I hereby give permission for examination and treatment.
I understand that I am responsible for all charges related to examination and treatment.

Patient's, Parent's or Guardian's Name _____ Date _____

Patient's Parent's or Guardian's Signature _____

For your convenience and safety, we use a computerized prescription program that will improve both the accuracy and convenience of prescribing your medications. *This program will allow for the electronic transmission of most of your prescriptions directly to your Pharmacy of choice and will eliminate your waiting time.* In most cases, it will also accommodate the transmissions of prescription to mail order pharmacies.

To use this new program, we need to collect some information from you on your pharmacy of choice. If you also have a mail order benefit program, please provide that information by selecting the appropriate box below.

Pharmacy Name _____

Street Name _____

City, Zip _____

Phone (_____) _____

Millennium Medical & Surgical Foot Specialists **PATIENT MEDICAL HISTORY**

Patient: _____ Birthdate: _____ Date: _____

Primary Care Physician: _____ Other Physician: _____

REVIEW OF SYSTEMS

General Symptoms

Have you been in good general health?	Y	N
Unexplained fatigue or frequent headaches?	Y	N
Unexplained weight gain or weight loss?	Y	N

Eyes

Eye disease or injury?	Y	N
Blurred or double vision?	Y	N
Glaucoma or Macular Degeneration?	Y	N

Ears, Nose or throat

Nose bleeds, persistent sore throats?	Y	N
Hearing loss or ringing in ears?	Y	N

Cardiovascular

Chest pain, irregular heart beat, heart disease	Y	N
Shortness of Breath?	Y	N
Swelling of hands, ankles or feet?	Y	N
Cardiac event or heart attack?	Y	N
High Blood pressure?	Y	N
Circulation Problems?	Y	N
Fainting?	Y	N

Respiratory (Pulmonary)

Chronic or frequent coughs?	Y	N
Wheezing or Bloody coughs?	Y	N
Asthma or Bronchitis?	Y	N
Pneumonia?	Y	N
Tuberculosis?	Y	N
Emphysema (COPD)?	Y	N

Gastrointestinal (Stomach)

Changes in bowel habits?	Y	N
Nausea or vomiting?	Y	N
Rectal bleeding or blood in stool?	Y	N
Abdominal pains?	Y	N
Loss of appetite?	Y	N
Stomach Ulcers?	Y	N
Gall Stones?	Y	N

Genitourinary

Frequent, painful or burning urination?	Y	N
Blood in urine or dark urine?	Y	N
Kidney stones or Kidney diseases?	Y	N
Changes in bladder habits?	Y	N
HIV or sexually transmitted disease?	Y	N
Jaundice, Hepatitis or Liver diseases?	Y	N

Females: Approximate date of Last menstrual period? _____

Are your periods: regular irregular

Endocrine

Hormone problems?	Y	N
Excessive thirst or urination?	Y	N
Skin becoming more dry?	Y	N
Recent change in hat, glove or shoe size?	Y	N
Diabetes? (Insulin Oral medication)	Y	N
Thyroid problems?	Y	N
Scarlet fever or Mononucleosis?	Y	N

Musculoskeletal

Surgery of Hip, Leg, Foot or Toes?	Y	N
Joint pain, stiffness, swelling or bursitis?	Y	N
Weakness of muscles or joints?	Y	N
Muscle pain or cramping of legs or feet?	Y	N
Lower back pain?	Y	N
Cold hands or feet?	Y	N
Arthritis?	Y	N
Polio, Muscle disease, or Paralysis?	Y	N
Unequal leg length?	Y	N
Knee pain? Right Left	Y	N
Bunions, Hammer toes or other foot changes?	Y	N
Gout?	Y	N

Integument

Rash or itching?	Y	N
Changes in skin color or texture?	Y	N
Recent appearance of non-healing sores?	Y	N
Recent changes in moles, or freckles	Y	N
Keloids or thickened scars?	Y	N
New or spreading skin lesions?	Y	N
New or enlarged varicose veins?	Y	N
Toenail Problems?	Y	N
Skin Problems?	Y	N

Neurological

Convulsions or seizures?	Y	N
Numbness or tingling in hands, legs or feet?	Y	N
Head injury, tremors or paralysis?	Y	N
Memory loss, confusion or Alzheimer's disease	Y	N
Depression,anxiety, or insomnia?	Y	N
Stroke? Year _____	Y	N

Hematological

Slow to heal after cuts, or recurrent infections?	Y	N
Bleeding or bruising tendency?	Y	N
Transfusion?	Y	N
Blood clots?	Y	N
Enlarged glands?	Y	N
Low Iron in blood or other Anemia's?	Y	N
Blood Disorders?	Y	N

Cancer

Have you had cancer?	Y	N
Location of cancer _____		
Are you now under treatment for cancer?	Y	N

Allergic/Immunologic

History of allergic or adverse drug reaction? Y N

(Penicillin Sulfa Tetracycline Aspirin Motrin, Tylenol Codeine)

Other Medication? _____

Food: _____

Materials: Latex Metals Adhesive tape

Other Materials _____

Airborne: _____

Is there anything the doctors should be aware of? _____

_____

_____

_____

Authorization and release To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. **It is my responsibility to inform to doctor's office of any changes in my medical status or medication use.**

I authorize Dr. Salter or his healthcare staff to perform an evaluation and treatment as needed.

Patient or Authorized signature: _____ Date: _____

Printed Name if other then patient: _____

Millennium Medical & Surgical Foot Specialists **PATIENT HISTORY OF COMPLAINT**

PATIENT: _____ Date: _____

What is the reason for your visit: _____

_____

_____

☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other _____

☐ Right toes ☐ Right Foot ☐ Right Ankle ☐ Right lower leg

☐ Left Toes ☐ Left foot ☐ Left Ankle ☐ Left lower leg

When does problem occur? _____

_____

How long ago did problem start? ☐ ___ Days ☐ ___ Months ☐ ___ Years

☐ **NO injury**. Onset was: ☐ Gradual ☐Sudden When did it start? _____

☐ **Injury** not related to work or automobile. How did it happen? _____

☐ **Injury** related to work ☐ fall ☐ Lifting ☐ Twisting ☐ Crushing

☐ **Injury** related to sport. Date of injury_____

☐ **NO injury**, but related to work. About when problem begin? _____

☐ **Auto accident**. Date of Accident _____ What happened? _____

_____

Have you been seen in an emergency room or by another physician for this problem? Y N

Have you had tests, x-rays or scans for this problem? Y N _____

On a scale of 1-10 (10 is the worst pain) ***how severe is the pain?*** 1 2 3 4 5 6 7 8 9 10

What is the* quality *of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is ☐ Constant ☐ Intermittent (comes & goes) ☐ Occasional

Does the pain wake you from sleep? Y N Does the pain keep you from sleeping? Y N

Since my pain started, it is ☐ Getting better ☐ Getting worse ☐ Unchanged

What makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Lying in bed

☐ Wearing shoes ☐ Removing shoes ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting

Which makes your symptoms better? ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ other _____

Have you used medication for this problem? Y N What medication have you used? _____

Have you had any other treatments for this problem? ☐ Injection ☐ Brace or Cast ☐ Cane/crutches ☐ Physical therapy

Current work Status? Your Occupation: _____ (Standing Job ☐Sitting Job

☐ Not employed ☐ Retired ☐ Regular work ☐ Light duty

☐ Disabled due to this problem ☐ Disabled due unrelated problem

Last day of regular employment? _____

Hospitalization,Surgery or Illnesses related to this complaint? ☐ None

_____

_____

Dr. Review _____ Date: _____

☐ Dr. Michael Salter Rochester 2017

MEDICAL AND SURGICAL FOOT SPECIALISTS

PATIENT MEDICATION LOG

TODAY'S DATE: _____/_____/_____

PATIENT NAME: _____

BIRTH DATE: _____/_____/_____

MEDICAL ALERTS: _____

PRIMARY CARE PHYSICIAN: _____

ALLERGIES:

_____

_____

_____

☐ **NO KNOWN DRUG ALLERGIES**

DATE	MEDICATION	REASON FOR MEDICATION OR CONDITION

REVIEWED BY: _____ Date: _____

REVIEWED BY: _____ Date: _____

REVIEWED BY: _____ Date: _____

INSURANCE CARRIER AGREEMENTS AND DISCLOSURES

COMMERCIAL INSURANCE AGREEMENT AND DISCLOSURE

PATIENT: _____

INSURANCE COMPANY: _____

I UNDERSTAND THAT ALL TREATMENT RENDERED TO ME WILL BE SUBMITTED TO MY INSURANCE COMPANY FOR PAYMENT. IF, AFTER MY INSURANCE COMPANY IS BILLED, IT IS DETERMINED THAT I HAVE NOT MET MY YEARLY DEDUCTIBLE AND/OR HAVE COPAYMENTS, I AGREE RESPONSIBILITY FOR PAYMENT OF THESE BALANCES TO:

DR MICHAEL SALTER - MILLENNIUM MEDICAL & SURGICAL FOOT SPECIALISTS.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES FOR COLLECTION SERVICES ON UNPAID BILLS OVER NINETY DAYS.

I UNDERSTAND AND ACCEPT THAT I AM RESPONSIBLE FOR PAYMENT TO DR. MICHAEL SALTER-MILLENNIUM MEDICAL & SURGICAL FOOT SPECIALISTS OF ALL CHARGES SUBMITTED TO MY INSURANCE COMPANY FOR SERVICES PROVIDED, BUT DENIED FOR PAYMENT DUE TO SPECIFIC POLICY COVERAGE LIMITATIONS.

PATIENT OR AUTHORIZED AGENT

SIGNATURE: **X** _____ DATE: _____

MEDICARE AND MEDI-GAP
INSURANCE AGREEMENT AND DISCLOSURE

PATIENT: _____

SECONDARY INSURANCE COMPANY: _____

I UNDERSTAND THAT ALL TREATMENT RENDERED TO ME WILL BE FIRST SUBMITTED TO MEDICARE AND THEN TO MY MEDI-GAP OR SECONDARY INSURANCE COMPANY. IF, AFTER MEDICARE AND MY SECONDARY INSURANCE COMPANY HAVE BEEN BILLED, AND IT IS DETERMINED THAT I HAVE NOT MET MY YEARLY DEDUCTIBLE AND/OR POLICY COPAYMENTS, I AGREE TO RESPONSIBILITY FOR PAYMENT OF THESE BALANCES TO:

DR. MICHAEL SALTER - -MILLENNIUM MEDICAL &SURGICAL FOOT SPECIALISTS.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES FOR COLLECTION SERVICES ON UNPAID BILLS OVER NINETY DAYS.

PATIENT OR AUTHORIZED AGENT

SIGNATURE: **X** _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

THE UNDERSIGNED PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE ("AGENT') OF THE PATIENT ACKNOWLEDGES THAT HE OR SHE PERSONALLY ACCEPTS THE **MILLENNIUM MEDICAL & SURGICAL FOOT SPECIALISTS** NOTICE OF PRIVACY POLICIES ON THE DATE INDICATED BELOW.

PATIENT OR AUTHORIZED AGENT

X_____ DATE:_____

SIGNATURE

_____

PATIENT'S NAME

_____

INFORMATION ABOUT "AGENT' (ATTACH APPROPRIATE DOCUMENTATION)

_____

TITLE OR RELATIONSHIP TO PATIENT

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IN GENERAL, THE HIPAA PRIVACY RULE GIVES A PATIENT THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION. THE PATIENT IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF THEIR HEALTH BE MADE BY ALTERNATIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE INSTEAD OF THE INDIVIDUAL'S HOME.

PLEASE COMPLETE THE FOLLOWING:

☐ eMAIL _____@_____
- ☐ OK TO SEND A STANDARD MESSAGE
- ☐ LEAVE MESSAGE WITH CALL BACK NUMBER

☐ CELL PHONE ( ) _____
- ☐ OK TO LEAVE DETAILED MESSAGE
- ☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

☐ HOME PHONE( ) _____
- ☐ OK TO LEAVE DETAILED MESSAGE
- ☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

☐ WORK PHONE ( ) _____
- ☐ OK TO LEAVE DETAILED MESSAGE
- ☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

PREFERRED CONTACT METHOD FROM OUR OFFICE
☐ CELL PHONE ☐ EMAIL ☐ HOME PHONE ☐ WORK PHONE

FOR WRITTEN COMMUNICATION FROM OUR OFFICE:

- ☐ OK TO MAIL TO MY HOME ADDRESS
- ☐ OK TO MAIL TO MY WORK ADDRESS
- ☐ OK TO FAX INFORMATION TO: ( ) _____
- ☐ OTHER METHOD, PLEASE SPECIFY _____

TO PROVIDE INFORMATION TO SPOUSES, SIGNIFICANT OTHERS, COMPANIONS, PARENTS/CHILDREN, OR GUARDIANS, WE MUST HAVE WRITTEN PERMISSION. PLEASE STATE TO WHOM WE MAY GIVE YOUR PERSONAL HEALTH INFORMATION.

IT IS OK TO SHARE MY PERSONAL INFORMATION WITH THE FOLLOWING PEOPLE:

_____, Spouse/Companion/Significant Other/Parent/Child/Guardian

_____, Spouse/Companion/Significant Other/Parent/Child/Guardian

SIGNATURE: _____ DATE: _____/_____/_____